Identifiable Data Set for End Stage Renal Disease Composite Rate Payment System Description, Fields, and Definitions

FILE DESCRIPTION

This file contains select claim level data and is derived from 2005 ESRD facility outpatient claims, updated through December 31, 2005 that is, claims with dates of service from January 1, 2005 through December 31, 2005 that were received, processed, paid, and passed to the National Claims History file by December 31, 2005. This file includes about 3 million claims, paid to dialysis facilities under the Composite Rate Payment System. This is a flat file available on cartridges. The record length is 6373, and the blocksize is 32,760.

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10 PUF-TYPE                                  PIC X(4).
10 PUF-PROVIDER-NUMBER                       PIC X(6).
10 BILL-TYPE                                 PIC X(2).
10 FROM-DATE                                 PIC S9(5) COMP-3.
10 DIAGNOSIS-CODES                           PIC X(50).
10 RLT-COND-73                               PIC X.
10 RLT-COND-80                               PIC X.
10 SERVICE-LINE-COUNT                        PIC S9(3) COMP-3.
10 SERVICE-LINE-GROUP.
  15 SERVICE-LINE
       OCCURS 0 TO 300 TIMES
         DEPENDING ON SERVICE-LINE-COUNT.
    25 SERVICE-REVENUE-CODE                  PIC X(4).
    25 SERVICE-HCPCS                         PIC X(5).
    25 SERVICE-DATE-OFFSET                   PIC S9(3) COMP-3.
    25 SERVICE-UNIT-COUNT                    PIC S9(7) COMP-3.
    25 SERVICE-REV-PAYMENT                   PIC S9(9)V99 COMP-3.
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CLAIM AND SERVICE LINE FIELD DEFINITIONS:

CLAIM FIELD DEFINITIONS

PUF-TYPE: Indicates type of claim (these will all be ESRD).

PROVIDER-NUMBER: The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

BILL-TYPE: The code derived by CWF to indicate the type of claim submitted by an institutional provider. (these will all be 72)

FROM-DATE: The date of service in quarter/year format

DIAGNOSIS CODES: The principal ICD-9-CM diagnosis code, followed by other diagnoses, identifying the diagnosis, condition, problem or other reason for the outpatient encounter/visit shown in the medical record to be chiefly responsible for the services provided.

RLT-COND-73: A value of Y in this field indicates self-care training.

RLT-COND-80: A value of Y in this field indicates that beneficiary received home dialysis in nursing and Skilled Nursing Facility (SNF).

SERVICE-LINE-COUNT: The number of revenue codes appearing on the claim.

SERVICE LINE FIELD DEFINITIONS

SERVICE-REVENUE-CODE: The provider-assigned revenue code for each cost center for which a separate charge is billed. A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Revenue center code “0001” is used to identify the claim “totals” line.

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SERVICE-HCPCS: Healthcare Common Procedure Coding System (HCPCS) code for an item or service, is a collection of codes that represent procedures.

SERVICE-DATE-OFFSET: the number of days from the actual claim date of service. The actual claim date of service is not provided except in quarter/year format, and can be found in the“FROM-DATE” field. This “SERVICE-DATE-OFFSET” field can be used to determine when line items were provided in comparison to other line items on the claim. The value “-999” will be used to indicate that the original line date of service was missing from the data.

SERVICE-UNIT-COUNT: The number of units of the item or service delivered.

SERVICE-REV-PAYMENT: The computed 2005 Medicare payment for a line item based. This amount does not include deductibles or coinsurance.